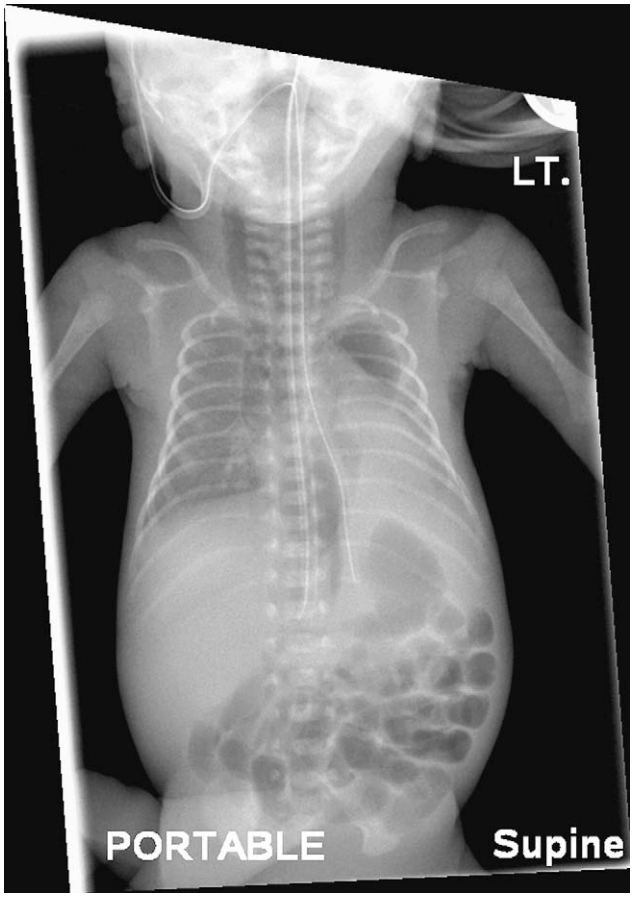

FIGURE 1. Chest roentgenogram showing the endotracheal tube below the diaphragm and mediastinal emphysema.

infants; thus we elected to conservatively manage this severe neonatal tracheal injury. If instability had persisted, several more aggressive management options were considered, including selective main stem intubation with a 2.0-mm endotracheal tube (or small chest tube) or surgical repair via sternotomy/thoracotomy with or without cardiopulmonary bypass.

Based on the short-term outcome of this neonate, we concur and extend the conclusions of Denlinger and colleagues[1] that the degree of membranous or cartilaginous posterior tracheal injury in neonates does not mandate surgical repair if there is clinical stability. Furthermore, we emphasize the known importance of low-pressure and spontaneous ventilation if possible when tracheal injuries are present. Similarly, close follow-up will be necessary to ensure that granulation tissue does not lead to stricture formation and that tracheoesophageal fistulas do not develop.

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Reply to the Editor:

We were interested to learn that the indications for nonoperative management of large tracheal lacerations can be safely extrapolated to the pediatric population, and even to premature neonatal patients, as noted by Dr Baird and colleagues. Not only was this treatment strategy tolerated by the patient but, also, the large tracheal defect has apparently healed well without evidence of early stenosis. Longer-term follow-up will determine whether tracheal strictures will develop. Notably, the airway injury in this neonate involved both membranous and cartilaginous portions. It is generally believed that cartilaginous injuries in adults are less likely to be successfully managed without operative intervention. Perhaps further experience will lead us to an understanding that anterior tracheal injuries in the adult population can also heal without surgical intervention as long as the patient is able to ventilate and remains clinically stable.

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PREOPERATIVE CORONARY STUDY IN PATIENTS WITH ACUTE AORTIC DISSECTION AND ENDOCARDITIS

To the Editor:

We read with interest the recent article of Kilian and coworkers[1] on intraoperative coronary angiography in patients with acute aortic dissection and endocarditis. We congratulate the authors. This technique, presented in the past by other groups and used now by the authors on 7 patients, is fascinating; however, we believe a few more points should be addressed.

The authors treated 2 patients with acute aortic dissection and 5 patients